Liability and Managed Care

Committee on Medical Liability

ABSTRACT. This statement is intended to inform practitioners of the liability issues arising from managed care arrangements. Although it is not possible for pediatricians to completely insulate themselves from all liability in these areas, this statement offers a number of strategies to decrease the chances of being successfully sued. However, because case law within this realm is constantly evolving in each state, these serve only as guidelines and are subject to both local and emerging developments.

Although managed care has existed since the 1930s, it has only recently affected the majority of pediatricians. With managed care as a way of life for at least 80% of pediatricians, a new set of medicolegal issues is emerging. In addition to this, a pediatrician now has to contend with a new set of financial as well as medical issues. The most common areas that affect pediatricians include utilization review, compensation through financial incentives, termination policies for both the physician and the patient, abandonment, and limitation on referrals and testing. Although pediatric care often involves parental, as opposed to patient, decision-making, for ease of reference in discussing these issues, the term “patient” is used throughout this statement. This term is used with the understanding that it refers to either the minor patient or the guardian(s), as appropriate and as consistent with the Academy’s policy.

UTILIZATION REVIEW

In the past, pediatricians made decisions about a patient’s treatment based primarily on what the pediatrician perceived were the patient’s medical needs and wishes. Due to the public’s increased awareness of the high cost of medical care, its demand to curb those costs, and the fiscal methods used by managed care to meet these demands, the pediatrician can often be placed in a very uncomfortable and legally risky position.

The cornerstone of legal cases dealing with the issue of utilization review is Wickline v State of California. The court in that case stated that the responsibility for deciding a patient’s medical course belonged to the treating physician, not to the insurance company. It went on to say that those administering utilization review programs could be held liable if the programs were administered in an arbitrary or negligent manner, and that the treating physician could not point to the health care payor as the liability “scapegoat.” A more recent case, Wilson v Blue Cross of Southern California, upheld portions of Wickline but greatly increased a health maintenance organization’s liability in the area of utilization review, although it did not absolve the physician from liability for inappropriate or improper treatment.

As case law continues to evolve in this area, it is important for pediatricians who are subject to utilization review to consider the following:

Plan Issues
- Reviewers must include at least a registered nurse or physician, preferably a pediatrician.
- Any case in which approval was denied must be reviewed by a physician, preferably a pediatrician.
- There must be a reasonable appeals process in place.
- The physician reviewer must be available to discuss any denials over the phone.

If a contract does not contain the above-mentioned provisions, the pediatrician needs to renegotiate the contract with the managed care company.

Pediatrician Issues
- Pediatricians should use the entire appeals process to render the most appropriate care for their patients.
- Pediatricians should document all conversations regarding utilization review issues.
- In the rare case that a pediatrician cannot reach a reasonable agreement with utilization reviewers, the pediatrician should discuss with the patient the option of paying independently for medical care received outside of his or her insurance coverage. It is important to document this “informed refusal” if the patient chooses to refrain from receiving the noncovered care.

INCENTIVE OR BONUS PROGRAMS

Although it has never been proved that incentive programs really do change physician behavior and decrease medical costs, they nonetheless continue to be used by managed care organizations. It is very difficult to defend one’s position in cases in which there is direct financial gain attached to medical decision-making. Pediatricians considering involvement with a program that uses incentive or bonus plans should consider the following:

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. PEDIATRICS (ISSN 0031 4005). Copyright © 1996 by the American Academy of Pediatrics.
• In most cases, a broad-based program is easier to defend. These programs are based on the actions or expenditures of a group of physicians instead of one individual physician and on a time frame that considers the actions over a month, quarter, or year instead of each individual episode of care.

• A program that is tied not only to utilization but also to quality of care is far superior to a program that does not consider quality.

TERMINATION
Another area of risk is that of termination of the contract. Any contract that a physician signs should clearly state both the company’s and the physician’s responsibility with regard to termination of the contract. The contract should list what events or actions can lead to termination by either party and the length of time necessary to terminate the contract.

The contract should also discuss issues surrounding termination of the physician/patient relationship. These include, but are not limited to, physician notification of patient termination and under what conditions a physician can terminate his or her relationship with a patient. Many managed care organizations have clauses in the contracts that allow termination of the physician-patient relationship in the event of a patient’s continuous gross noncompliance with the treatment plan or a patient physically or verbally abusing the physician. In all cases, the events used to justify termination must be well-documented.

When a patient-physician relationship is to be terminated, it is important for appropriate, timely notification to occur so as not to constitute abandonment.

ABANDONMENT
Although it may ultimately be the responsibility of the managed care company to notify patients that their primary care physician is no longer a provider within their organization, it is prudent for the physician to notify the patient of a change of status within the organization. To best reduce the risk of an accusation of abandonment, at least 30 days before leaving, the physician should notify each patient affected by registered mail. Included in this letter may be a list of providers within the organization who are available to the patient.

Notification alone, however, may not be sufficient to avoid a claim of abandonment. If the care of the patient cannot be transferred expeditiously, the patient may continue to have a right to care despite the lack of a contract between the physician and the managed care organization. The physician similarly may be bound to provide treatment to a patient even in the event of the plan’s financial insolvency.

LIMITS ON TESTING AND REFERRALS
There are a variety of methods that managed care organizations use to limit referrals and testing. One method commonly used is the physician “report card.” The company keeps track of the number and cost of testing and referrals ordered by each physician. The physician is then compared with his or her peers. These numbers can be very misleading depending on a variety of factors, such as patient age and severity of illness within the physician’s practice. The pressure that might be associated with this type of oversight may cause an individual physician to withhold necessary testing and/or referrals inappropriately.

Another way in which a managed care company may involve itself in the referral process is by limiting those specialists to whom a primary care provider can refer. It is important that a pediatrician be able to make referrals to pediatric medical subspecialists and pediatric surgeons. There is legal precedent for physician liability based on making referrals to a subspecialist that the pediatrician knew or should have known was inappropriate or incompetent. If a plan denies a referral to a pediatric medical subspecialist or pediatric surgeon, the pediatrician should notify the patient of the option of paying out-of-pocket for the consultation and, if necessary, obtain a written “informed refusal.”

HOLD HARMLESS CLAUSES
“Hold harmless” clauses are often found within managed care contracts. These clauses place the physician at total risk in the event of a medical malpractice suit and relieve the managed care organization of any liability. A pediatrician must attempt to negotiate with the managed care company to have such a clause deleted. If unsuccessful in removing the “hold harmless” clause, the pediatrician must check with his or her malpractice carrier to ensure that this clause does not negate the malpractice coverage. Noncoverage by a carrier in this situation must render the clause nonnegotiable because the pediatrician would be shouldering an unacceptable risk.

Another nonnegotiable clause is one that censors physician-patient communication. Termed “gag clauses,” these provisions prohibit physicians from fully discussing treatment options with their patients and thereby compromise a physician’s ethical and legal duty to the patient. Pediatricians must not sign contracts that contain such provisions.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
Presently, ERISA laws, which protect self-funded employee benefit plans, prevent many patients from successfully suing their health care entity for negligence. In Corcoran v United Healthcare,4 the court stated that the health care plan did make medical decisions but only “in the context of making a determination about the availability of benefits under the ERISA plan.” Under certain conditions ERISA may limit not only the ability of a patient to claim malpractice but also the monetary amounts available from a lawsuit. Recently, however, the ERISA preemption provisions have come under attack and their scope may become limited.

RESPONSIBILITY OF PEDIATRICIAN IN MANAGED CARE
As managed care continues to expand, so will the legal pitfalls that an individual pediatrician may encounter. It is the responsibility of each pediatrician to keep up with this ever-evolving area of medical care and thereby continue to offer the best medical care
possible at the least possible risk to both patients and providers.

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Mark S. Reuben, MD, Chair
Jan Ellen Berger, MD, MJ
Jeffery I. Berman, MD
Charles H. Deitschel, MD
Ian R. Holzman, MD
Julius Landwirth, MD
Steven M. Selbst, MD
Consultants
Kenneth V. Heland, JD
American College of Obstetricians and Gynecologists
Holly Myers, JD
Insurance Consultant

Alain J. Montegut, MD
American Academy of Family Physicians
Raymond C. Seligson, MD, JD
Resident Consultant

References
1. Emmons DW, Simon C. Recent Trends in Managed Care: Socioeconomic Characteristics of Medical Practice. Chicago, IL: American Medical Association; 1994
2. Wickline v State of California, 192 Cal App 3d 1630 (Cal Ct App 1987), review dismissed, remanded, 741 P2d 613 (Cal 1987)
3. Wilson v Blue Cross of Southern California, 222 Cal App 3d 660 (Cal Ct App 1990)
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